CONNECTICUT HEALTH INSURANCE EXCHANGE PLANNING GRANT STAKEHOLDER MEETING CONSUMER ADVOCATES

DATE: May 3, 2011 and May 12, 2011

LOCATION: Office of Policy and Management, 450 Capitol Avenue

INVITED TO PARTICIPATE:

Connecticut Health Policy Project
National Multiple Sclerosis Society
National Alliance on Mental Illness
Family Support Network
Legal Assistance Resource Center of Connecticut
Office of the Health Care Advocate
Advocacy for Patients with Chronic Illness
Connecticut Voices for Children
Child Health and Development Institute
Medical Resources Management
Mental Health Association of Connecticut
Hispanic Health Council
Connecticut Association for Home Care and Hospice
New Haven Legal Assistance Association
Universal Health Care Foundation
Connecticut Conference of Churches
Connecticut Health Foundation
Community Renewal Team
Connecticut AIDS Resource Coalition
NAACP-CT
AARP-CT
Connecticut Area Health Education Center
The Connecticut Multicultural Health Partnership
Asian Pacific American Affairs Commission[1]
African-American Affairs Commission
CT Commission on Health Equity
Urban League

MEETING ATTENDEES:

Tesha Imperati, Director of Programs and Services, CT Family Support Network
Jennifer Carroll, Executive Director, CT Family Support Network
Ellen Andrews, Executive director, CT Health Policy Project
Jane McNichol, Executive Director, Legal Assistance Resource Center of CT
Alicia Woodsby, Director of Public Policy, NAMI-CT
Jennifer Jaff, Executive Director, Advocacy for Patients with Chronic Illness
Sheldon Toubman, staff Attorney, NHLAA
Sharon D. Langer, Senior Policy Fellow, CT Voices for Children
Mary Alice Lee, Senior Policy Fellow, CT Voices for Children
Vicki Veltri, Healthcare Advocate, Office of the Healthcare Advocate
Laura Morris, Outreach Coordinator, Data Analyst, Office of the Healthcare Advocate
Kevin Kelly, President MRM, for CHDI
Shirley Bergert, Attorney, CT Legal Services
Dominique Thornton, General Counsel, Mental Health Association of CT
Phil Wyzok, President/CEO, Mental Health Association of CT
Dr. Marie M. Spivey, Chair, CT Commission on Health Equity
Theresa Nicholson, Assistant Vice President, CRT
Glenn Cassis, Executive Director, African American Affairs Commission
Nakul Harnurkar, Legislative Analyst, Asian Pacific American Affairs Commission
Arvind Shaw, Commissioner, APAAC
Claudio Gualtieri, Senior Program Specialist, AARP
John Erlngheuser, Advocacy Director, AARP
Patricia Baker, President/CEO, Connecticut Health Foundation
Jill Zorn, Senior Program Officer, Universal Health Care Foundation of CT
Patty Levandowski, ULGH
Shawn Lang, Director of Public Policy, CT AIDS Resource Coalition
Egondu Onyejekwe, V. Chair Communications, CT Multicultural Health Partnership

Background

The public engagement plan for Connecticut (the State) in planning for an Insurance Exchange consists of public forums held throughout the State as well as stakeholder meetings organized by professional group category. Over 85 organizations were invited to attend a stakeholder meeting to discuss Exchange topics such as structure, operations, market reforms, accountability, transparency, and sustainability. Questions were sent to each organization prior to their meeting. The feedback the State received from these questions was used as the framework for the discussion. Meetings were conducted by a neutral facilitator and recorded/transcribed. This document reflects an integration of initial written comments from the invited organizations listed above, as well as discussion from the meeting. It is intended as a summarized snapshot of the initial perspective(s) of the groups that participated. **It is not intended to represent final thoughts or positions**.

ESTABLISH A RESPONSIVE AND EFFICIENT STRUCTURE	
Should Connecticut consider joining a multi-state Exchange?	
Not in best interest of consumer. But can still learn from other states.	Pros include a larger pool, a larger array of plan selection and providers, and savings. Consider: • Collaborating with other states on back-office and evaluation without the problems mentioned above • Getting benefit of other states wisdom through discussions, even if doing own state Exchange • Creating small partnerships with New England states Cons include differences between states, potential for diminished rights and protections, timing, and difficulty in joint agreements: • There are unique coverage mandates in CT that could be lost in a multi-state or regional Exchange • Has anyone analyzed CT's mandates compared to other states, this may be a good idea. • Navigators are familiar with CT market, will not be as familiar with resources in other states • Ease of enrolling in state programs, such as HUSKY, could be complicated across state borders • Not in the best interests of consumer, at least at outset, due to unique coverage mandates and state programs in CT • May need flexibility to make changes at state level • Consider impact on different minority groups
Should CT administer the individual and small group markets separately or jointly?	
Jointly, with a single risk pool.	• Facilitates interactions and transitions between and among different programs • Leverages purchasing power • Individual and group policies, and HUSKY policies, should have overlapping provider networks, formularies, and plans[1]
Consider all the rules that would need to be changed.	• If the pools are merged in the Exchange, you also have to change the rules for the entire market • There would be more rules to change in Connecticut than there were in Massachusetts because the two markets are more differently operated

[1] Comment made in a letter dated 6/22/11 by Consumer Advocacy groups*: "We agree that the individual and small business markets should be merged; however, we contend that plans should be clearly identified on the Exchange so consumers can tell the difference between individual and small business plans."

What employer size should Connecticut allow into the Exchange?	
Up to 100, as early as 2014.	• Small business should include single employee firms • Leverages purchasing/bargaining power to include more firms/employees • Use data analyses that have already been done by Health Risk Connector Authority[2] • Need to analyze very carefully, educate, and think about timing and scale
Decide based on experience.	• Decide about including larger groups over 100 closer to 2017, based on experience
Start with smaller group.	• Start with smaller group and evaluate the strengths and weaknesses of that before going up • There are unknowns about this population. Therefore, people are being cautious. However, we should not be so cautious that we exclude people who could benefit.

GOVERNING BOARD	
Membership should be inclusive but also carefully considered.	• Board members should have expertise in 2 areas: (*although could be one or two areas, as CA has been having trouble finding people with expertise in both*) – Individual insurance – Small business insurance – Health plan administration – Health care finance – Delivery system admin, financing and admin of public programs – Health insurance plan purchasing • Board should have representatives from existing public programs; the Exchange has to dovetail with them so they need this knowledge • Providers should have input but perhaps not a vote – their perspective may be helpful in that they are doing a great deal of system development and peer organization work. These are issues that the Exchange needs to consider. However, there is concern regarding conflict of interest. For example, the benefit package is based on evidence-based practice and not who is on the Board • No insurance agents or brokers, nor vendors seeking to do business with the Exchange should be on Board – has to be perceived by public as not captive to industry • Guard against the Noah's Ark type of board – one of everything
Include meaningful consumer representation.	• Board should consist of consumer representatives: one individual, one small business, one from an organization[3] • Consumer advisory committee that is fully staffed and meets periodically with Board • Individual and small business representatives will be especially important if those groups are pooled • Ensure that they are "real consumers" • Familiar with publicly financed Medicaid and delivery of these programs and services

[2] Comment made in a letter dated 6/22/11 by Consumer Advocacy groups*: "We assume you mean Massachusetts, although there is no entity with that precise name, so we don't know what data analyses to which you are referring."

[3] Comment made in a letter dated 6/22/11 by Consumer Advocacy groups*: "Under 'Governing Board', the Administration did not accept our recommendations in passing the Exchange-authorizing legislation in that there are no consumer representatives, no consumer advisory board, etc. We hope that this will be remedied in the future."

	• Familiar with children and adults with disabilities, mental health issues • Consider cultural, ethnic, and geographic diversity of state in selection of consumer representatives • Not just window-dressing • This should be required in order to develop consumer impact statement on any significant policy the Board is considering
Establish additional rules and protections.	• Consider the CA language on conflicts • Board shall meet in public and be subject to FOIA • All Board members who can, should purchase insurance in the Exchange • Exchange should be tax-exempt and not-for-profit • If quasi-government, allow collective bargaining and meet all requirements applicable to employers • Salaries should be in line with salaries for state employees

ADDRESS ADVERSE SELECTION AND THE EXTERNAL MARKET	
Should CT allow a dual market, a hybrid market, or should it require that all individual insurance be sold through the Exchange?	
Dual market.	• Undocumented immigrants are not allowed in Exchange and need a venue to purchase insurance • A dual market will increase choices for family planning and other services that the ACA limits for women
Should CT implement any additional mechanisms to mitigate adverse selection?	
Require consistency of plans in and out of Exchange.	• Should require the same premiums, plan design, cost sharing, commissions, marketing, enrollment in and out of Exchange • Prohibit creation of separate affiliates of insurers that sell outside the Exchange only • Risk adjustment services and risk case management monitored to ensure there is no incentive to avoid more costly patients, to steer people one way or the other • Need to enforce comparable Provider panels with no incentive to make a provider panel for expensive conditions more available in Exchange than out • HUSKY DSS hired a secret shopper which is an inexpensive way to identify serious problems • Although value-based insurance design is laudable, must not be used to steer patients in/out of Exchange • Make sure brokers, agents, navigators do not have incentive to steer people away from the Exchange[4]
Robust monitoring and evaluation.	• Robust monitoring and evaluation – there are going to be new and creative ways to get around the rules and we need to be watching because if we are not watching, we will not know[5]

[4] Comment made in a letter dated 6/22/11 by Consumer Advocacy groups*: "Under 'Should CT implement any additional mechanisms to mitigate adverse selections?' we believe we provided specific examples of mechanisms to ensure that brokers and agents who act as navigators do not have incentives to steer consumers away from the Exchange. Brokers/agents who are navigators should not be allowed to be paid twice, as both brokers and navigators. Brokers/agents who wish to be navigators should have sales agreements with all plans offered on the Exchange."

	• Marketing practices and benefit design will require robust monitoring – both proactive monitoring including approval of activities, and mechanisms to identify and react to abuses
Additional rules	• Insurers should be required to submit notice and justification of premium increases before the increase takes effect, with ample opportunity for consumers to participate in a public hearing on the rate increase • The Exchange should adopt and implement a quality improvement plan that provides incentives for improving health outcomes, preventing hospital readmissions, improving patient safety, reducing medical errors, and implementing wellness initiatives • The Exchange will be required to transmit a significant amount of information related to tax credits and exemptions from the individual mandate. In so doing, the Exchange should be required to make every effort to protect the confidentiality of consumers with penalties for breeches

SIMPLIFY HEALTH INSURANCE PURCHASE	
What issues should Connecticut consider in establishing a Navigator program?	
Define role.	• Navigators should carry out public education, provide impartial information, facilitate enrollment, and provide references[6] • Must be tailored to be linguistically and culturally appropriate, work with speech and hearing impaired, persons with disabilities, and other persons who are disadvantaged, culturally or physically isolated • Clarity about qualifications, expectations, training, role definition
Be inclusive.	• Identify groups that would do Navigator work anyway and provide them with modest grants • Award small grants to any group with a good idea, measure effectiveness, then target resources to most successful • When MA gave out small grants, it kept everyone engaged. Although the grant is not enough to hire someone, it is enough to become salient, to create engagement so all community organizations, not just health organizations, are out promoting the Exchange. "Healthcare for All" received a large grant to bring everybody together. • Needs to be a system approach: Everyone in the system working together; cross-education about the parts of the system • Navigators should be representative of the population. They should be diverse groups. • Look to for examples and assistance – SHIP or CHOICES; Community Action Agencies, CRT, UConn and the AHEC commodores; Ryan White case managers
Establish additional rules.	• Should provide feedback to the board at least quarterly • Should have no conflict of interest • No Board member should be a Navigator

[5] Comment made in a letter dated 6/22/11 by Consumer Advocacy groups*: "Under robust monitoring and evaluation, we believe we gave quite a few specific examples of things that should be prohibited by health plans to avoid adverse selection: Cash rewards, gym memberships, mail order pharmacy options, weight loss and smoking cessation benefits were some of our suggestions. In addition, while one aim of monitoring and evaluation was to avoid adverse selection, we had significantly longer, more detailed suggestions in our initial written comments on monitoring and evaluation for additional purposes."

[6] Comment made in a letter dated 6/22/11 by Consumer Advocacy groups*: "Navigators should be required to provide information on and enrollment in tax credits, in addition to insurance, HUSKY, etc."

	• If individual and small group markets separated, appropriate to have some Navigators serve only one of those markets.
Thoughtfully address disparities.	• Plan to address health disparities • Develop a specific strategy of what to tackle first • When training navigators, tell them what to look for: smoking, obesity, hypertension, diabetes.[7] If we just tell them, okay, here, you are supposed to address disparities, without us actually providing them a systematic plan of resolving these issues in these communities, then we are just going to get the same kind of mush • Really consider the cultural and linguistic needs of the different populations you are trying to reach, because efforts fail when we do not pay attention to this
Work hard to get it right.	• We have people who are eligible for HUSKY that never enroll so we know we are not so good at this right now, so it is going to take a monumental effort • We have a lot to learn from MA and how they use community-based organizations to really go out and find people • It starts with the motivation that we want to enroll as many people as possible; the culture, that has to be number one – people deserve the right to have insurance and to be insured and our job is to make sure that they get that
Do not need to be licensed, but should be consistently educated.	• How do you ensure accountability – that's not necessarily by licensure • Requiring Navigators be licensed will steer this the wrong way; you will get the wrong people as Navigators • Licensure and certification are different things: a license says you work with somebody, a certification says I know what needs to get done and can help you • Plan well for where the education is going to come from and make sure it is consistent across all levels who are going to be interacting with the public
Consider small businesses	• Under the ACA, the employer has to need to know exactly who did not take insurance and why; consider fulfillment of that reasonability – both how the employer helps educate people, and who helps educate the employer
What should Connecticut consider regarding the role of insurance brokers and agents?	
Effective regulation and transparency.	• Brokers and agents should not be Navigators, but also should not be excluded from the Exchange because small businesses are accustomed to purchasing through them[8] • Connecticut is a broker-heavy state, therefore it is hard to say no role at all; the market will determine their role

[7] Comment made in a letter dated 6/22/11 by Consumer Advocacy groups*: "Under "thoughtfully address disparities," we believe the issues related to disparities go far beyond smoking, obesity, hypertension, and diabetes. Navigators should be looking for any and all obstacles to affordable, appropriate health care of any kind, for reasons specifically related to cultural, ethnic and linguistic differences."

[8] Comment made in a letter dated 6/22/11 by Consumer Advocacy groups*: "With respect to brokers/agents as Navigators, our group agreed that we had given this issue some consideration since we submitted our initial written comments, and that we (or at least some of us) had come to the conclusion that, in light of the critical role brokers/agents play with respect to small businesses, it would be wrong to bar brokers/agents from being Navigators for small business. What we said, as noted above, is that broker/agents should not be on the Board of the Exchange; that they should not be compensated twice, as a broker/agent and as a Navigator; and that there should be assurances that broker/agents would not steer consumers to or away from the Exchange by ensuring that they were paid the same either way, and that they had contracts to sell all products on the Exchange. Some of this made it into your summary, but not quite all of it."

	• Must sell products on the Exchange, can not steer purchasers away from Exchange • Robust monitoring and safeguards need to be in place to ensure brokers and agents are not doing anything to prohibit access. Make sure they are not steering people in or out of the Exchange because they get a different commission. Make sure they are not making exorbitant commissions or setting rules so not transparent • The ACA does not effectively regulate them so determine how we will. Look at existing regulations in CT and consider next steps. • Transparency in terms of understanding what their role is going forward, and making sure that it fits with the broader aims of health care reform • Clear disclosure of costs • Brokers do not always add value and sometimes they are just built into the system • Do not want to see money going to brokers that could go to clients needing • services

INCREASE ACCESS TO AND PORTABILITY OF HIGH QUALITY HEALTH INSURANCE	
Should CT allow any plan that meets Qualified Health Plan standards to be available in the Exchange, or should CT establish additional requirements? If additional requirements, what would you recommend? What would be impact of those requirements?	
Should be an active purchaser.	• Limit plans, use selective criteria, negotiate premium prices. (MA Connector research shows consumers prefer smaller number of options) • Ensure high standards, provide meaningful choice rather than a confusing array of options • This approach does not have to reduce consumer options. (In MA, no plan to have applied has ever been rejected, although they are considered an active purchaser) • Concern is that not enough plans will sign up, which will quickly defeat the Exchange, as happened in Maine a year ago • Every insurer should be required to offer at least one bronze, silver, gold, platinum, and catastrophic plan • Each plan should be made available as child-only • Preserve existing CT benefit mandates • The Exchange can be a driver for change, in terms of the State agenda, improving health outcomes, and improving delivery systems • Plans should compete and the Exchange should be empowered to negotiate • Preference should be given to insurers willing to provide continuity of care for consumers cycling between Medicaid, CHIP, and Exchange, and BHP if selected
Dental benefits	• Should ensure at least one qualified dental plan available (including essential pediatric benefits) • May offer health and dental jointly as long as offered separately as well
Should CT consider establishing the Basic Health Program? What would the BHP offer as a tool to facilitate continuity of coverage and care?	
Yes.	• The BHP should be planned for while the Exchange is being planned.[9] • This is especially important for the HUSKY A population (133 to 185 FPL). There will be financial incentives for the State to move people over 133% of FPL out

[9] Comment made in a letter dated 6/22/11 by Consumer Advocacy groups*: "The Administration and General Assembly agreed to evaluate the Basic Health Program. We urge the Administration to work with the SustiNet Health Care Cabinet to take up this issue as early as possible."

	of Medicaid in 2014 and so where do they go? • Could have advantages if designed well: continuity, coverage for legal immigrants barred from Medicaid, could help to avoid churning in and out of the Exchange. • Eliminates problems with variation in income, being eligible and then ineligible for subsidies, and having to pay that back afterwards. The BHP is important because cost sharing may be unaffordable in the Exchange, even with subsidies – premiums alone for 150% FPL may be $54 per month, not including out of pocket expenses beyond that. • Excess federal funds should be used to increase provider reimbursement rates. Do not dismiss the idea of excess funds; the fiscal note was wrong.
Make it a Medicaid look-alike.	• Make it easier to keep parents and children in Medicaid covered by the same plan by mirroring the benefits, cost-sharing, and protections of Medicaid so that when kids stay on Medicaid and CHIP, everyone has the same benefits. • Just put the BHP into same system as other public programs, Medicaid, Husky, Charter Oak, all under one system (include in the move to ASO) • For those who go up and down between Medicaid and the BHP, it can actually be invisible to them – the same program, the same doctors, the same cost sharing protections, and the same coverage
Consider all possible options.	• Is there a simpler way of having a basic stripped down plan with universal healthcare access to primary care and using a reinsurance product to just look after catastrophic care?[10] • Take a look at DSS and how it currently interacts with the community action agencies • One idea is a wrap around but they do not work for two reasons: they are very cumbersome, and they get taken away politically, as in Part D wrap around (so the BHP is probably a better option)
Some considerations.	• Different medical needs of that population • Impact on Exchange pool • Cost implications for consumers • Impact for legal immigrants excluded from Medicaid

How can CT structure its Exchanges to maximize continuity of coverage and seamless transition between public and private coverage? (E.g. as a person moves from Medicaid, subsidized and non-subsidized markets)	
Similarity between plan options.	• Basic Health Plan (see above) • Overlap of providers between at least one Exchange plan, and public programs for people who go back and forth – some plans in the Exchange should include CHCs and safety net providers in provider networks[11]
Administratively simple.	• No penalty or fee to terminate Exchange coverage if offered employer-sponsored coverage • A single entry point to track a person's movement from one option to the

[10] Comment made in a letter dated 6/22/11 by Consumer Advocacy groups*: "As far as we understand it, the first item under "Consider All Possible Options" presents a radically different proposal than the Medicaid look-alike Basic Health Program that was proposed by the consumer advocate group that met on May 3 and is not a proposal that we would expect to support. We believe that a Medicaid look-alike Basic Health Program is by far the best way to protect those individuals between 133 and 200% of the Federal Poverty Level."

[11] Comment made in a letter dated 6/22/11 by Consumer Advocacy groups*: "We strongly urged that certain specialized providers like AIDS clinics and FQHCs be enrolled as in-network providers in plans both inside and outside the Exchange. You refer to overlap of providers, but we meant these particular types of providers that might affect adverse selection."

	other, as long as HIPAA standards are maintained • Single, streamlined, seamless application process for Medicaid and Exchange • Variety of portals to compare coverage including online, telephone, Navigator, producers • Rapid, seamless, gap-free transitions • Move between plans without administrative complexity
Plan well.	• We need to understand who the uninsured and underinsured populations are and plan accordingly; need to interact with those communities to get necessary information

ENSURE GREATER ACCOUNTABILITY AND TRANSPARENCY	
What information should CT include for outreach to most effectively engage consumers? How should the information be presented?	
Multiple avenues for engagement.	• Establish a means for in-person consultation and presentations, in addition to website and hotline
Standardized format.	• Should be clear whether plan is HMO, PPO or POS, and these terms should be defined[12] • Develop one standardized application • Material must be translated and ethnically marketed so that all residents can avail of these services • Voice system that responds to frequently asked questions
Varied information.	• Marketing must be based on appropriate care[13] • Information should be at physician or group level • Information about health plan performance • Objective outcome data by specific procedure or disease • Consumer satisfaction
Carefully designed.	• Easy comparisons between cost, quality, and service, with sufficient detail to drill down • Work with diverse groups that may be harder to assist because of barriers such as language, culture, familiarity with insurance • Look at federal website to compare plans, that works well • Make it understandable, not overly complex • Extensive testing of Exchange, marketing materials, application form, and any other materials, with diverse focus groups • Should be made clear that state and federal privacy laws will be adhered to • Study available research and experiences
How should Connecticut ensure ongoing feedback and input about accountability, operational issues, and suggested improvements?	
Multiple avenues for input and evaluation.	• Must adapt over time • All audits of Exchange (by anyone) should be posted on website • Reports to the GA, meeting minutes, and contact info should be public • Consumer evaluations, secret shoppers, consumer focus groups, consumer

[12] Comment made in a letter dated 6/22/11 by Consumer Advocacy groups*: "In addition to having information about whether a plan is an HMO, PPO, POS, etc., there should be access (a link) to a plan's formulary and provider directory."

[13] Comment made in a letter dated 6/22/11 by Consumer Advocacy groups*: "Marketing materials should be approved by the Exchange Board. We do not know what you mean when you say "marketing must be based on appropriate care." We disagree that information should be at the physician or group level UNLESS that is IN ADDITION to other marketing directly to consumers."

	forums, point of service surveys should be used • Aggregate and publish healthcare advocate complaints • Benchmarks and goal setting must be part of a performance improvement process • Advisory councils, Healthcare Advocate, consumer advocates should be used • Use information collected through this process in plan certification • Impartial evaluation • Priority should be given to racial and ethnic disparity reporting and the specific impact that it has on life expectancy
What information, beyond that required under the ACA and implementing regulations, should Connecticut require of plans? How much of this information should be shared with consumers accessing the Exchange?	
Varied information should be available.	• Insurers should be required to make claims payment policies and practices publicly available on websites: provide information on enrollment and disenrollment; data on claims denials numbers and appeals; data on rating practices; information on rights under the ACA; and other information required by HHS • Uniform billing and payment policies • Notice and justification of premium increases before they go into effect • Reporting on racial and ethnic disparities • Availability of culturally and language appropriate services around the state • Information that takes into account incongruence between western medicine and ancestral beliefs and practices • Protect confidentiality when transiting info/data

SELF SUSTAINING FINANCING	
How should the Exchange's operations be financed beginning in 2015? How might the State's financing strategies encourage or discourage participation in the Exchange; Affect the reputation of the Exchange, and affect accountability, transparency and cost effectiveness?	
Broad-based.	• Broader-based funding is better; do not load it all on the people using the Exchange • Make sure fees are not a disincentive to use the Exchange • Most states charge a user fee to insurers listing products on Exchange (assessments on premiums) • Consider charging a reasonable fee to small businesses receiving admin services • HRA (current high-risk pool) funds can be rolled into the Exchange (2014 there will be no pre-ex conditions, no need for fund) • State appropriation • User fees • Provider fees • Combination of these • Sell ads on the Exchange website (may impact sense of impartiality)[14]
Police for waste, fraud, and abuse.	• Plan to police for waste, fraud and abuse through AG • Attorney General already has extraordinary powers under federal law to investigate Medicaid fraud and abuse, so this role makes sense[15]

[14] Comment made in a letter dated 6/22/11 by Consumer Advocacy groups*: "It appears that someone suggested selling advertisements on the Exchange. We strongly disagree. The Exchange itself should not in any way appear to be promoting a plan, a provider, a treatment – anything related to health care. And ads of any kind will provide clutter."

What issues should be considered regarding state requirements for additional benefits above the minimum essential benefits? What funding sources should be considered for the cost of additional benefits?	
Think long-term.	• Connecticut's existing coverage mandates should apply to all plans offered in the Exchange • May be a false question of how to pay for (a study mandated by legislature on cost of mandates shows many mandates are not as expensive as people suggest) • Be as broad as possible in assessing costs of mandates benefits and include savings long-term

ADDITIONAL EXCHANGE FUNCTIONS	
Beyond the Exchange's minimum requirements, are there additional functions that should be considered for Connecticut's Exchange? Why?	
Quality and choice.	• Ensure every plan (individual and group) meets cost sharing limits of ACA • Encourage insurers to offer low and high deductible plans • Searchable provider database to determine which plans their providers participate in • Formulary available electronically, with any information about limitations • Should not allow changing provider network or formulary between open enrollment periods • Provide calculator on website to determine actual cost • Follow-up with all consumers who apply for insurance to ensure process completed and they can access benefits • Quality improvement plan to provide incentives for improving health outcomes, preventing readmissions, improving patient safety, reducing medical errors, and implementing wellness initiatives • Develop complaint process for Exchange, Navigators, and plans • Minimum standards for affordability, quality and adequacy of provider network, collection of data on disparities, QI systems, data collection and reporting, provider access, and marketing • Measure, map, and report access for medical, dental, and behavioral services • Report on alternative medicine and therapies
IT	• Follow our HIPAA laws to avoid violating people's confidentiality • How can the Exchange drive adaptation of electronic health records
Address disparities.	• Consider SustiNet recommendations to address health disparities • Measure health equity • Strategic plan for elimination of health disparities • Collect data on health disparities to be used re: prevention and making system changes
Should CT consider setting any conditions for employer participation in the small group exchange (e.g. minimum percent of employees participating, minimum employer contribution, limits in the range of product benefit values that may be selected by employees, etc)?	
Unsure.	• Do not oppose a provision stating that employers reserve the right to determine criteria for coverage and the amount of the employer contribution • Concerns about making sure people have access

[15] Comment made in a letter dated 6/22/11 by Consumer Advocacy groups*: "We disagree that the AG's Office has "extraordinary powers to control fraud and abuse under federal law." Although the AG's Office has civil authority, the Chief State's Attorney's Office has jurisdiction over all criminal matters."

What should be the role of the Exchange in premium collection and billing?	
No role.	• The insurance companies are already doing that; let the insurance companies do what they do best – we pay the insurance premium to them and they manage those accounts[16]
Help simplify system.	• Set and enforce Policies • Make it simple and convenient • Automatic payroll deduction for small employers (and sec. 125 pre-tax) or debit for individuals • Could be helpful to people with multiple employers

ADDITIONAL COMMENTS	
Cultural and Linguistic competence.	• All written materials must be culturally and linguistically appropriate • Oral interpretation services for any languages primary to at least 5% of Connecticut residents (there may be pushback from insurers but it is not an outrageous expense and this is not optional) • All insurers must meet this standard • Explain things in as simple terms as possible, clean, and with no lawyerly language
Consumers with Special Needs.	• Separate toll free # for speech and hearing impaired • Sign language interpreter at all meetings of Exchange and presentations • All written materials must be available in Braille or audio format • All presentations at handicapped accessible locations • Provide audio and video versions on internet • Insurers prohibited from discouraging enrollment of individuals with complex health needs – penalty if done more than 5x or withdrawn from Exchange if systemic • Consideration of needs of adults with disabilities who do not fit into the typical insurance mold • BHP could help • In essential benefits and mandates, robust comprehensive benefit for people who have needs not served by the average package
Electronic communication with DSS.	• Must be able to communicate eligibility between the Exchange and DSS without duplicate entry • Communicate with Department of Corrections to ensure inmates enroll within 30 days of release • With concern to privacy protections, ensure family and friends can advocate or be spokesperson • DSS subcontractor still using paper applications sent by courier • Do not add even more layers for very vulnerable low income and disabled people, make them jump through extra hoops

[16] Comment made in a letter dated 6/22/11 by Consumer Advocacy groups*: "You state that insurance companies are already billing and collecting premiums. However, in the small business market, this often is the role of brokers. They should be allowed to continue to fulfill this role."

	• DSS modernization and improvements are coming out of Raymond vs Rowland ADA litigation; should be coordinated with development of the Exchange so systems work together effectively
Due process and appeals and exceptions.	• Streamline notices so that they address eligibility/non-eligibility of various programs all together • Notices and hearing referral systems should be well planned to ensure efficiency and cost reduction • All basic due process hearing rights requirements apply – this should done properly from the beginning because that infrastructure is already in place and we just need to make sure it is done correctly/effectively • Should be possible to have a single streamlined administrative proceeding that allows you to challenge everything. If done correctly, you can catch and resolve a lot of problems short of litigation or other costly ways to proceed • Exceptions and appeals process should be clinically sound, with objective independent third-party and prompt decision as patient's condition mandates • Regarding appeals of benefit decisions, CT currently has a detailed process for managed care and most people would agree that this current system works pretty well, therefore, we already have a good model, but it might be incumbent upon the Exchange to look for patterns or problems if there is a certain insurer with an undue amount of appeals or something similar • Exchange should be very responsible in terms of proactively monitoring what is going on, the products they are responsible for, and its clients, but the Exchange has to be monitored as well

[1] Comment made by Nakul Havnurkar of the Asian Pacific American Affairs Commission: "The APAAC Board, after much discussion, generally agrees with the consolidated comments that DPH provided to "stakeholders". The only reservation it has is the adequacy of tracking and reporting of insurance exchange data by ethnicity. This is important because it allows the healthcare access of the many ethnic communities in Connecticut. As far as we can tell, this issue was not mentioned in the stakeholder discussion."

*Letter dated 6/22/11 submitted by: Jane McNichol, Legal Assistance Resource Center of CT; Domenique S. Thornton, Esq., Mental Health Association of Connecticut, Inc.; Alicia Woodsby, MSW, National Alliance on Mental Illness, CT (NAMI-CT); Jennifer Carroll, CTA Family Support Network; Sheldon Toubman, New Haven Legal Assistance; Shirley Bergert, Connecticut Legal Services; Mary Alice Lee, Connecticut Voices for Children; Shawn M. Lang, CT AIDS Resource Coalition; Grace Damio, MS, CD/N, Hispanic Health Council; Jan VanTassel, Connecticut Legal Rights Project; Ellen Andrews, Connecticut Health Policy Project; Jennifer C. Jaff, Advocacy for Patients with Chronic Illness, Inc.